TESTIMONY SUBMISSION FOR HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
Hearing on Current Hospital Issues in the Medicare Program
May 20, 2014

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The Texas Organization of Rural & Community Hospitals is a trade organization of the approximately 180 rural hospitals in Texas. Our organization appreciates the opportunity to offer written testimony to the House Ways and Means Subcommittee on Health.

RECOVERY AUDIT CONTRACTOR PROGRAM

Our organization would like to go on record as strongly supporting efforts by the federal government and the Centers for Medicare and Medicaid Services (CMS) to prevent, detect and counter fraud in the health care industry. Those who intentionally steal from the system should be aggressively punished. The problem at times, however, is that the Medicare and health care financial and billing systems have become extremely complicated over the years and very much subjective. Any given patient visit to the doctor can result in a billing code marked from a long list of potential billing codes, all of which may be medically correct. We have all experienced this in our personal physician's office where a number on a sheet of paper is quickly circled which will mean something to somebody later. The most appropriate billing code can often be subject to second guessing and different opinions – none of which constitute fraud.

The Recovery Audit Contractor (RAC) program has been an effort to make sure the health care system circles the correct number and doesn't intentionally circle the wrong number, especially when it means a higher payment. The program was needed and has done some good work. Unfortunately, the design of the program has also created problems in the health care industry and has resulted in payments being yanked away from health providers who provided legitimate services.

The overarching problem that the rural hospitals of Texas see is the method of payment for RAC auditors. To pay based on mere allegations has resulted in a "bounty hunter" environment. Congress must change this system. Auditors should not receive gain nor be incentivized to make allegations without a sound medical basis. They should be paid for their work and their efforts, independent of the outcome and any final recovery by the government. They should feel pressured to be fair and do the right thing – not to make a recovery no matter what. We would never consider paying IRS agents based their audit findings. We would never pay the police solely based on how many people they can pull over. Why do we treat health providers this way?

A second readjustment that Congress must provide is the huge inequity in how far auditors can go back versus the period for a hospital or other providers to make a correction or adjustment in billing. Medicare only allows providers to bill, rebill, or otherwise adjust billing for one year after the services are rendered. Yet auditors can go back and look at five (5) years (referred to as a four year look back

plus the billing year). The problem with this inequity is that if the auditor questions billing in years 2 through 5 (which is usually the case); the provider is beyond the one year billing window and cannot send in corrected or adjusted billing. The auditors then recoup or take back 100% of the payment. The providers get nothing.

The real inequity of this system is there are actual cases where a billing code is questioned, the auditors and the government took back all of the payment, but appropriate services were performed. Maybe a different billing number should have been used, but the hospital or provider provided services and ended up getting paid nothing. Further aggravating is the fact that in some cases, the provider should have been paid more and still gets nothing.

Congress must act to allow providers to rebill or adjust their billing for the same period of time that RAC auditors can look back and question their billing.

Admittedly, there is an appeal process that one would think would negate any inequities. Unfortunately, the RAC audit appeal process is not practical and tends to impede hospitals and other providers from receiving their grievance process. An indirect barrier for rural hospitals is that they do not have large internal financial and legal resources to fight this battle. Rather, because of their limited resources, they are often forced to turn to outside financial and legal consultants. The outcome for these hospitals – even when they win – is a loss as recovered funds end up being used to pay for the outside consultants. This is a shame as so many of the appeals are ultimately overturned. So, why take on that agony when the financial outcome for the hospital will be the same either way – you end up treating a patient for free.

In closing with regard to the RAC issue, Texas rural hospitals appreciate that this subcommittee has a growing awareness that there are problems with the RAC effort. And, hopefully many of these problems will be fixed with a proper balance of fairness to health providers yet allowing the government to continue with its efforts to seek out legitimate fraud. There are a number of bills pending related to RAC auditors. We believe that HR 1250 addresses the majority of the problems, yet does not limit appropriate efforts to go after fraud.

TWO MIDNIGHT RULE

A second issue before this committee which we would like to also comment on is the so called “Two Midnight” rule. We believe to arbitrarily predetermine that a patient stay in a hospital will be outpatient if it spans less than two midnights and will be inpatient if it spans more than two midnights is not based on any known medical science. The first question we continue to have is where does “midnight” come into play? At the very least, shouldn’t it be a span over 24 hours and less than 24 hours? And, how does 24 hours separate outpatient and inpatient.

We agree that if a patient's diagnosis is one that only requires a treatment plan on an outpatient status, it should be billed and paid as such. But, there are many other factors in play, especially in rural hospitals. It is not uncommon for rural physicians treating a patient to find themselves with very limited resources and ancillary support. Labs tests and radiology may have to be sent off elsewhere delaying the physician's ability to completely diagnose, prescribe a treatment plan, and implement it. Should those physicians simply say “take two aspirin and call me in the morning after I get the test results back?” We don’t think so and we don’t think Congress thinks that either. Those physicians need sound and appropriate medical information to properly treat and they may feel they must admit a patient to the

hospital in the meantime. Physicians know that with the patient already hospitalized (even if a so called observation stay), should the condition unexpectedly decline, the patient is where they need to be.

The “Two Midnight” rule takes the physician’s independent medical decision out of play and certainly does not factor in the variations in staff and medical resources at any given hospital. We are not sure what the appropriate timeframe may be, but we are certain you cannot draw a medical line between one midnight and two.

The “Two Midnight” must be reevaluated in a manner that takes into accounts appropriate patient treatment and not an arbitrary line based solely on saving money.